



# Patient Profile

DOCTOR: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

## PATIENT INFORMATION

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

What is your preferred method of contact.  Home Phone  Cell Phone  Email  Text via my cell phone

DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SEX:  F  M SS#: \_\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

## EMERGENCY CONTACT OTHER THAN PARENTS:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

## GUARANTOR / BILLING INFORMATION

MOTHER  FATHER  BOTH PARENTS  LEGAL GUARDIAN  SELF

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SS#: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SS#: \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

PRIMARY CARDHOLDER: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ GROUP #: \_\_\_\_\_ ID#: \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

PRIMARY CARDHOLDER: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ GROUP #: \_\_\_\_\_ ID#: \_\_\_\_\_

## CONFIDENTIAL AUTHORIZATION

Please list family members, and/or other persons with whom we may discuss patient's medical conditions. If the patient is a child, list those persons who are authorized to seek medical attention for the child with Pediatric Eye Specialists, LLP.

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_